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ORIGINAL ARTICLE

Perspectives from older adults with hearing loss on the link between hearing loss and dementia

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ABSTRACT

Objective: Research and public messaging increasingly highlight a potential link between hearing loss and cognitive decline. This study explores how older adults interpret, evaluate, and respond to messages linking hearing and cognition.

Design: Data was collected using semi-structured interviews and analysed using inductive thematic analysis.

Study Sample: Twenty-five Canadians aged 56–97 with self-reported hearing difficulties were recruited through research databases and community advertisements

Results: Four themes were identified. Participants constructed meaning about the hearing loss–dementia link through lived experience, personal theorising, and interpretations of scientific and professional information (Theme 1: Making Sense of the Message). They evaluated the need for action, the modifiability of hearing and cognition, and the link's personal relevance (Theme 2: Weighing the Need for Action). Some participants described the link as motivating initial help-seeking, persistence with hearing management, and/or reinforcement of past decisions (Theme 3: Perceived Impact on Hearing Health Behaviours). Certainty and trust in evidence, clinicians, and the hearing healthcare system shaped participants' interpretations and influenced their willingness to act (Theme 4: Certainty and Trust).

Conclusions: Public messages about hearing and cognition are filtered through personal and experiential frameworks, underscoring the importance of clear, balanced, and patient-centred communication when discussing hearing health and cognition.

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Introduction

Research over the past decade has suggested that hearing loss may contribute to cognitive decline and the development of dementia (Deal et al. 2017; Lin et al. 2013, 2023; Livingston et al. 2024). A highly cited longitudinal study by Lin et al. (2013) found that older adults with hearing loss experienced faster cognitive decline over six years compared to those with normal hearing. *The Lancet* Commission on dementia prevention, intervention, and care identified hearing loss as the largest potentially modifiable risk factor for dementia in mid-life (Livingston et al. 2024). Although notable, the mechanisms behind the association remain unclear (Levett et al. 2025). Whether hearing aid use slows or prevents dementia also remains uncertain, as observational studies may be confounded and randomised controlled data remain limited (Dawes and Munro 2024). One recent large-scale randomised controlled trial (Lin et al. 2023) suggested hearing aids may reduce cognitive change over three years in older adults at elevated risk, though this change was not observed in the main study cohort. This finding suggests that some individuals, but not all, could cognitively benefit from hearing aids.

Although the hearing loss–cognitive decline association remains complex, it has become increasingly prominent in public discourse. News media and marketing materials often emphasise the potential implications for dementia risk, including claims that hearing aids may prevent or slow cognitive decline (Blustein, Weinstein, and Chodosh 2020, 2023; Herrmann et al. 2026). However, how older adults

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interpret these messages and whether they influence hearing healthcare engagement remain unclear.

Qualitative work has shown that adults actively make sense of their hearing difficulties within broader social, cognitive, and emotional contexts (Knudsen et al. 2013; Lu et al. 2024). People with hearing loss describe the practical challenges of managing hearing and how media, marketing narratives, personal experience, family history, and informal knowledge shape interpretations of hearing and cognitive health. However, research has yet to directly examine how older adults interpret messages that link hearing loss to cognitive decline or how these interpretations relate to their decisions about hearing care.

Understanding these interpretations is particularly important where the emotional and social significance of dementia is concerned. Many older adults report that dementia evokes fears of dependency, loss of autonomy, and threats to personhood (Maxfield, Peckham, and James 2024). Research on dementia worry shows such concerns can both motivate and inhibit health behaviours (Lee, Do, and Suhr 2021; Orom and Allard 2025; Werner, AboJabel, and Maxfield 2021), while social media analyses highlight the broader cultural shaping of dementia-related stigma and anxiety (Bacsu et al. 2025).

Although hearing loss has wide-ranging effects on health and psychosocial well-being, many adults remain hesitant to seek care, and hearing aid uptake remains low (Mick et al. 2021). Barriers include cost, accessibility, stigma, perceived benefit, and uncertainty about treatment (Lu et al. 2024; McMahon et al. 2021). Hearing healthcare experiences further shape engagement, with patient-centred communication, trust, and individualised care central to uptake and sustained use (McNeice et al. 2025). Insufficient or overly technical communication may leave patients feeling unheard or disempowered, particularly when discussing sensitive topics such as cognitive decline (Coleman et al. 2018; Parmar et al. 2022).

Taken together, this literature suggests that older adults are navigating messages about the link between hearing loss and dementia from competing sources of evolving evidence, public and commercial messaging, lived experience, and subjective concerns about cognitive decline. These factors may shape how information is understood and acted upon within hearing healthcare, where engagement is often inconsistent and influenced by practical and psychosocial barriers. Little is known about how older adults interpret and understand these messages or how interpretations relate to care decisions. As the hearing loss–dementia link becomes increasingly prominent in clinical and public discourse, understanding these interpretive processes is important for informing effective communication about hearing and cognitive health.

The present study addresses this gap by deploying semi-structured interviews to explore how older adults make sense of the hearing loss–dementia link. It is concerned with understanding the insights of older adults with hearing loss with regard to hearing and cognitive health, and how meaning-making processes shape perceptions of relevance and/or hearing health behaviours. Our work aims to provide a greater understanding of the significance of the hearing loss–dementia link in audiological care.

Methods

Participants

Twenty-five older adults took part in the study. Recruitment materials stated that eligible older adults (aged 55+) should "experience difficulty with [their] hearing," but a formal diagnosis of hearing loss was not required. Participants confirmed their eligibility upon email contact with the researcher. No participants dropped out after participation commenced. Ages ranged from 56 to 97 years (M = 72.3). Roughly equal numbers of male and female participants were recruited (13 males, 12 females). Participants were English-speaking residents of Canada. Fifteen participants owned hearing aids, 1 wore a cochlear implant, and 9 did not own any hearing devices. All participants reported no formal diagnosis of cognitive impairment. Detailed demographics are presented in Table 1.

Recruitment

Participants were recruited through a Canadian research institution's participant database ($n = 11$), local chapters of a national hearing advocacy group ($n = 11$), advertisements on Kijiji, a popular Canadian classifieds website ($n = 2$), and word-of-mouth ($n = 1$). Details about the study were kept broad and did not mention the hearing loss–dementia link to minimise priming effects and reduce the likelihood of participants seeking information about the topic prior to the interview (see Supplemental Materials for recruitment script). No relationship was established with participants prior to participation, and no details about the interviewer were disclosed outside of the fact that she was a research assistant in an auditory lab at a research institution. Recruitment continued until the research team judged that the dataset

Table 1. Participant characteristics ($n = 25$).

Age			
Mean, SD, (range)	72.3	8.7	(56–97)
Gender			
Male	13		
Female	12		
Education			
High school diploma	6		
College degree or apprenticeship	7		
Bachelor's degree	5		
Postgraduate degree	7		
Ethnicity			
White	20		
Indigenous	2		
Jewish	2		
South Asian	1		
Immigration status			
Born in Canada	17		
Immigrated to Canada	8		
Hearing devices			
Hearing aids	15		
Cochlear implant	1		
No device	9		
Hearing loss–dementia link awareness			
Previously aware of link	19		
Previously unaware of link	6		
Hearing abilities (SSQ-12)			
Mean, SD, (scale range)	5.6	1.8	(0–10)
Subjective Cognitive Decline (SCD-9)			
Mean, SD, (scale range)	3.7	2.1	(0–9)

Note. SSQ-12 scores range from 0 to 10, with higher scores indicating better self-reported hearing ability. SCD-9 scores range from 0 to 9, with higher scores indicating greater subjective cognitive decline.

contained sufficient depth and diversity to address the study aims.

Participants were compensated $20/hour (prorated at $10/half hour). All participants provided informed consent and agreed to audio recording. The study was approved by the Baycrest Research Ethics Board (REB# 24-17).

Procedures

Procedures consisted of one semi-structured, one-on-one interview followed by self-report questionnaires. Participants could choose in-person participation at Baycrest Health Sciences or remote participation (Zoom Video Communications, 2024). Questionnaires were completed on paper or via Qualtrics (Qualtrics, 2024), with verbal administration available upon request.

Interviews

Semi-structured interviews were conducted by SB (female research assistant, MSc) using a guide collaboratively developed by the research team and a community advocate with lived experience of hearing loss. The guide was piloted with two participants (excluded from analysis) and revised before data collection began (Supplementary Materials). The guide followed a flexible topical progression to explore participants' interpretations of the relationship between hearing loss and cognition, beginning with an open discussion of their hearing histories and experiences that allowed participants to guide the focus and direction of the conversation (see Supplemental Materials). This was followed by general questions about participants' memory and cognitive health, intended to ease the transition to the topic of cognitive decline. Discussion of the link itself was introduced either spontaneously when participants raised it or later via the prompt: "Have you ever heard anything about a possible link between hearing loss and cognitive decline?" This sequencing was intended to reduce premature framing of the hearing loss–dementia link; however, it may also have anchored subsequent interpretations of the link in these prior narratives, shaping how participants articulated their sense-making. The interviewer used the term 'cognitive decline' and adjusted this terminology based on participants' responses; participants frequently used 'dementia' and 'memory loss'. Participants unaware of the link ($n = 6$) received no explanation unless they asked; the interviewer instead explored related experiences or invited hypothetical reflection. When asked, the interviewer gave a brief, neutral answer and explored their reaction. Follow-up probes then explored information sources, reactions, reflections on personal hearing, information-seeking behaviours, and perceived influences on healthcare intentions or actions. Interviews lasted between 20 and 102 minutes ($M = 38.8$ minutes) and were audio-recorded. Field notes were not kept and transcripts were not returned to participants.

Questionnaires

Following the interview, participants completed questionnaires assessing subjective cognitive decline (SCD-9; Gifford et al. 2015), hearing abilities (Speech, Spatial, and Qualities of Hearing Scale; Gatehouse and Noble 2004), and demographics. Questionnaires were administered post-interview to minimise priming effects and were used to describe sample characteristics and contextualise interview findings, but were not included in qualitative coding.

Data processing and analysis

Audio recordings were transcribed by Otter.ai (Otter.ai, 2024) and edited for accuracy and readability. Potentially identifiable information, including names of workplaces, schools, and spouses, was removed, and pseudonyms were assigned to each

transcript. Transcripts were imported into NVivo (QSR International, Version 15) for analysis.

Inductive reflexive thematic analysis, following Braun and Clarke (2019), was conducted to ground the analysis in lived experience while recognising the active role of researcher subjectivity in knowledge production. SB, a research assistant new to qualitative research, conducted all interviews and initial coding, with transcript cleaning supported by two research assistants. She completed workshops on qualitative methods and received ongoing supervision from SLM (postdoctoral fellow) and AG (more than 25 years of experience in qualitative interviewing and thematic analysis). SB had no clinical audiology training or personal experience of hearing loss or dementia. Participants may have viewed her as an expert on the subject matter, which could have influenced responses.

Conversations with a community advocate with hearing loss, who reported wide curiosity about the link in her community, shaped the study's initial focus and, in turn, the analysis. The team's backgrounds are in auditory cognition, ageing, qualitative research, and social gerontology; none is a hearing care clinician. Members held neutral-to-positive views on hearing care and viewed some marketing of the link as overstated, which shaped the interview probes about care intentions and actions. These positions may have predisposed the analysis towards hearing healthcare engagement and behaviour change rather than broader experiences of ageing, disability, or distrust of the healthcare system.

No predefined coding framework or codebook was used. Instead, codes were developed inductively through iterative engagement with participants' accounts. Coding focused on participants' interpretations, evaluations, and responses to the hearing loss–dementia link. Interviews with participants unaware of the link were coded alongside the others, but responses to hypothetical prompts were interpreted as hypothetical reflections rather than reports of experience or behaviour. Related codes were clustered and refined through repeated engagement with the data into themes and subthemes representing patterns of shared meaning. Theme development was interpretive and supported by regular discussions with co-authors (SLM, AG, & BH), which supported reflexive discussion of developing interpretations; interpretations aimed to stay close to participants' words, though other readings are possible. Participants did not provide feedback on the findings. Reporting was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong, Sainsbury, and Craig, 2007; see Supplemental Materials).

Results

Four themes were identified, describing how participants interpreted, evaluated, and responded to messages linking hearing loss and dementia (Figure 1): (1) *Making Sense of the Message*, (2) *Weighing the Need for Action*, (3) *Perceived Impact on Hearing Health Behaviours*, and (4) *Certainty and Trust*. Quotations are identified by pseudonym, age, and hearing device status (HA = hearing aid user, CI = cochlear implant user, ND = no hearing device). † = participant previously unaware of the link.

Theme 1: making sense of the message

Theme 1 describes how participants constructed the plausibility and meaning of the hearing loss–dementia link through active sense-making. Rather than accepting or rejecting the message outright, participants worked to determine whether the link was plausible, coherent, and personally meaningful by drawing on lived experience, intuitive explanations, and external sources.



Figure 1. Four main themes and subthemes. The figure depicts four themes describing how participants interpreted and responded to messages about the hearing loss–dementia link. Each coloured shape represents one theme and its associated subthemes. Theme 1 (*Making Sense of the Message*) appears at the top, followed by Theme 2 (*Weighing the Need for Action*) and Theme 3 (*Perceived Impact on Hearing Health Behaviours*). Theme 4 (*Certainty and Trust*) is shown as a larger background shape behind the other themes, indicating that it influences processes across the other three themes.

Assessing the link through lived experience

Participants often used lived experience as a way of testing the plausibility of the hearing loss–dementia link. Experiences of hearing loss and cognitive decline among family members or peers sometimes shaped how meaningful or relevant the association appeared, even when not interpreted as evidence of causality:

> *… My mother developed hearing loss … and she also, at the same time, developed vascular dementia … So it's hard to know … was it a side effect, causal effect, contributing effect, who knows? But that's kind of how that has affected me. Has made me kind of jump on, like, taking it seriously.*
>
> *—Bonnie, 67, HA*

Other participants used observations of people with hearing loss to evaluate whether the association seemed plausible. One participant stated that "in [his] experience with older people, it's not just that it happens at the same time, that they get old and they lose their hearing and they lose cognitive capability," but rather that "hearing loss contribute[s] to a steeper decline" (Geoff, 65, ND).

Conversely, some participants used examples of individuals with hearing loss who maintained cognitive functioning to question the strength or universality of the association:

> *My dad lived to be 80 years old. He was … just about totally deaf. He had his wits about him … My uncle lived to be 94, and my aunt lived to be 96. And these were the deaf people in our family. So, no, [the link] doesn't scare me.*
>
> *—James†, 66, ND*

Another participant presented examples of well-known figures with hearing loss who retained high levels of cognitive functioning, framing hearing as one of many modalities for engaging with the world:

> *To my mind, your memory works independently of your hearing. I mean, you can be stone deaf and be a genius. Beethoven. So to me, there shouldn't be a link unless it's related to using hearing to learn … It's just one means of putting things in, right? Again, like Helen Keller.*
>
> *—Frank†, 78, HA*

Together, these accounts demonstrate how participants assessed the plausibility of the link by weighing lived experiences from their personal lives and the public sphere, which could support, complicate, or challenge their interpretations of the association.

Constructing explanatory coherence

Participants drew on existing understandings of health, ageing, and cognition to construct explanatory coherence, using mental models that made the abstract hearing loss–dementia message understandable and personally meaningful. For example, some described hearing as providing necessary input for maintaining cognitive function, using comparisons between the brain and a muscle that becomes weaker when unused:

> *Well to me, it seems intuitive that if you're in a world of silence, your brain's going to have less to process. And I would think that that could have something to do with dementia, simply because the brain isn't getting its exercise … if you're not hearing, you're missing a lot.*
>
> *—Mike, 78, HA*

> *I think if you experience hearing loss … it's just like not using your legs, I guess. Your memory is – if you don't hear anything … you're not using that. I could see it as an obvious result.*
>
> *—Diane†, 65, ND*

Participants also considered social pathways as possible explanations for the link between hearing loss and dementia, describing how hearing loss could limit social engagement and affect cognitive health. One participant suggested that reduced social engagement after hearing loss might be "impact[ing] [him] mentally … so, that might be the link" (James†, 66, ND), while another described how feeling socially disconnected made the association intuitive: "you're not being social anymore … you really do feel like you're on the fringe of life" (Pam, 69, CI).

Together, these accounts illustrate how participants used intuitive theories about cognition, engagement, and ageing to evaluate whether the association was logically coherent and personally meaningful.

Seeking external evidence and expertise

Some participants discussed how they sought external sources to help interpret the hearing loss–dementia link. For these participants, scientific sources, media, and healthcare professionals provided additional reference points for interpreting the association and integrating it with their existing understandings of hearing loss and dementia.

For example, some initially encountered the link while seeking information about dementia:

> *My father had Alzheimer's, so I've been doing a lot of reading about Alzheimer's and dementia, and one of the things they said there is [that] hearing can be a contributor … I know you can't prevent dementia 100%, but you can delay it or reduce the effects, and socialization is one of them … So that's another reason I would like to get better hearing.*
>
> *—Gary, 70, ND*

For some, information encountered through external sources prompted further questions and discussion with healthcare professionals. One participant sought further interpretation from his audiologist,

noting that "they may have more information than I have" (Ken, 71, ND).

Some participants sought clarification from the researcher regarding the nature of the link:

> *I mean, have they actually proven there's a big link? That if some people had had hearing aids earlier, they might not have had dementia? Have they proven that?*
>
> *—Mary, 67, HA*

Across accounts, participants worked to understand and evaluate the hearing loss–dementia link by negotiating multiple forms of knowledge that sometimes converged and sometimes conflicted. Some sought external information or professional expertise to address questions that could not be resolved through their own experiences or reasoning. Together, these processes shaped how participants understood the link and provided the foundation for considerations of actionability (Theme 2).

Theme 2: weighing the need for action

Theme 2 outlines how participants evaluated whether the hearing loss–dementia link might prompt meaningful and feasible actions in relation to their own lives. These evaluations were shaped by perceptions of agency, the modifiability of health outcomes, as well as broader beliefs about ageing.

Perceived agency and health modifiability

Participants evaluated whether they should take action in response to their knowledge of the hearing loss–dementia link, considering whether they had the capacity to influence potential outcomes, whether available strategies were likely to be effective, and whether recommended actions fit within their circumstances.

Some participants perceived limited opportunities for meaningful action because hearing loss or dementia risk was viewed as difficult to influence:

> *Maybe I'm not worried about my own case because there's nothing else we can do about my hearing loss anyway, so why worry about it?*
>
> *—Geoff, 65, ND*

> *Oh, now all of a sudden, I'm going to take a pill, or do some magic thing? Like, no, that's not going to work. So… it would only be out of curiosity and interest. It's not going to affect me at all.*
>
> *—Bonnie, 67, HA*

For others, potential responses to the link between hearing loss and dementia were not considered personally relevant within their circumstances. One participant questioned whether social engagement recommendations applied to him, noting that he had "worked alone all [his] life" and was someone who preferred to keep to himself (Dale, 72, HA).

In contrast, some participants described continued effort and engagement as ways they could actively influence cognitive outcomes:

> *I do think it probably plays a part. And I think it depends on what the hard of hearing person does, you know? If you can try and help yourself.*
>
> *—Vera, 84, HA*

Another participant connected cognitive health with continued intellectual engagement, stating that people who maintained this type of activity were "going to have fewer chances of getting dementia" (Paul, 68, HA).

Meanings of action in later life

Participants often interpreted the relevance of the hearing loss–dementia link through broader understandings of ageing, accumulated health risks, and acceptance of age-related change. As a result, some viewed it as one concern among many rather than a uniquely urgent threat. When hearing loss and cognitive decline were understood as part of the normal burdens of later life, the link was less salient, less alarming, and less motivating for action:

> *You know, I've reached a time of life where there are so many jeopardies, it's just one of them.*
>
> *—Fiona, 97, HA*

One participant framed adapting to hearing loss as a process of acceptance, not correction. Rather than motivating action, this participant spoke of absorbing the link between hearing loss and dementia into an acceptance of the limitations imposed by hearing loss:

> *… Grief is not about getting better. Grief is about acceptance, and about changing your focus and perspective to accommodate what it is that you can't change. I don't even fear that there's a link between dementia and lack of hearing, because if there is, it's just another thing that you have to accept, too.*
>
> *—Bonnie, 67, HA*

Others adopted a contrasting orientation, viewing later life as requiring continued effort to maintain health and wellbeing:

> *But I do think [hearing loss] can lead to dementia if you don't try and stabilize some of your other conditions. Some people just give up. They think, "I'm old now, and that's it." But I think if you really want to carry on enjoying life a bit, then you have to … start doing extra things and take extra care.*
>
> *—Vera, 84, HA*

> *You can't give up, you have got to keep working at it … Unfortunately, I think what happens is, people get*

old and they either don't have the energy for it, or they think it doesn't matter, "just leave me over here to die"… it shouldn't be that way.

—Pam, 69, CI

Across these accounts, participants weighed whether the hearing loss–dementia link represented something they could meaningfully act upon, influenced by broader health concerns, personal priorities, and beliefs about what could be changed in later life. These evaluations of actionability and relevance shaped if and how participants integrated knowledge of the link into their hearing health decisions (Theme 3).

Theme 3: perceived impact on hearing health behaviours

Theme 3 outlines how some participants integrated knowledge of the hearing loss–dementia link into decisions and actions around their hearing health. As described in Theme 2, many participants did not experience the hearing loss–dementia link as prompting new behavioural changes because it felt unactionable, irrelevant, or was absorbed into broader orientations of acceptance. However, others described how knowledge of the link shaped their hearing health behaviours over the course of their experiences with hearing healthcare.

Motivation to seek care

Some participants stated that knowledge of the hearing loss–dementia link motivated them to seek hearing care by adding urgency to existing concerns or reinforcing the importance of timely treatment. Some participants described the link as contributing to decisions they had previously delayed:

I thought, I better get them [hearing aids]. Insurance plan's running out, now I know this – I better just go and get them.

—Mary, 67, HA

It's been a period of time that I've been thinking that I'm having reduced hearing. So [the link is] just one more thing that added to it. I finally made the move and talked to people at Costco, and I'm seriously considering now going to a hearing specialist… So yeah, that contributes to the overall philosophy of your hearing, how important that is.

—Ken, 71, ND

Knowledge about the link prompted responses beyond participants' own hearing care, motivating some to encourage friends and family to seek hearing care:

I took her to get hearing aids… Because I said to her, "You don't talk to enough people," and a few people were concerned about her declining, not remembering things. And so, because I'm aware of [the link], I notice it more.

—Paul, 68, HA

Maintenance of hearing health behaviours

For participants already engaged in hearing care, some described the link as additional justification for continuing existing behaviours:

It motivated me to try to keep doing what I was doing, even though I struggle with hearing, like, keep going … I decided to embrace my hearing loss and do whatever I can to make it better, if that meant getting the best hearing aids, or going to support groups, or whatever it takes.

—Cheryl, 71, HA

For some participants, the link also highlighted the limitations of available interventions and prompted consideration of alternative approaches. Geoff, whose hearing loss resulted from physical trauma and was not effectively addressed by traditional hearing aids, described wanting to explore other options:

I have thought of it every once in a while, about pushing a little harder to see… if there's somebody who's doing research about the effects of restoring hearing, who would be interested in… helping me get to an operation that tries to connect these three bones or whatever.

—Geoff, 65, ND

Reinforcement of past decisions

Participants who had already sought care often stated that learning about the link reassured them that their earlier decisions were worthwhile for their hearing and cognitive health.

Well, I guess it makes me glad that I've treated it, or tried to treat it, so I hope I'm hearing at my best.

—Wayne, 83, HA

Similarly, several participants noted that their knowledge of the link did not motivate behavioural change, but rather reinforced that they were doing the right thing in maintaining their hearing and cognitive health:

I can just keep doing what I'm doing, trying to keep my mind active, and keep interested in things.

—Jim, 74, HA

Participants described their knowledge about the link as providing reassurance that they were managing their hearing loss appropriately and, in turn, supporting their cognitive health.

Theme 4: certainty and trust

Theme 4 describes how participants' engagement with the hearing loss–dementia link was shaped by their confidence in the evidence and their trust in the

sources communicating it. These considerations contextualised how participants made sense of the link (Theme 1), weighed the need for action (Theme 2), and enacted or modified hearing health behaviours (Theme 3).

Certainty and credibility of the link

Participants varied in the degree to which they regarded the hearing loss–dementia link as established and meaningful to their lives. Some expressed high certainty, using definitive language to describe the connection: studies had "prove[n] the correlation between hearing loss and dementia" (Paul, 68, HA); the two were "definitely connected" (Margaret, 66, HA); and there was "a direct link from hearing to dementia" (Pam, 69, CI).

Others were less certain, questioning either the nature of the association or whether sufficient evidence existed to support it:

> *I'm not really sure what the link is exactly… No, I don't understand the direct correlation.*
>
> *—Beatrice, 56, ND*

For some, this uncertainty extended to the credibility of the information itself. Fiona (97, HA), for example, characterised what she had encountered about the link as "all gossip and hearsay."

For some participants, uncertainty about the link was connected to feelings of discomfort. One participant described repeatedly encountering information about a possible connection between hearing and memory loss, and he ultimately stopped reading because it was upsetting:

> *Sometimes I saw hearing loss may be connected to memory loss… I read [the article], and then again, they feed more, so I read again, give more. So I saw it a few times, but because it will make me upset, I didn't go in there. But I don't know [if] it's true or not.*
>
> *—Vishal, 75*

One participant expressed that greater certainty about the evidence would be a prerequisite for hypothetical action, and that evidence of a causal relationship might make her more willing to pursue hearing treatment:

> *If they said for sure that the less you can hear, the more mental crazy you're gonna go, for sure, then I would probably look into hearing aids or whatever. Nobody wants to lose it when they get older.*
>
> *—Miriam†, 67, ND*

Thus, participants did not simply accept or reject the hearing loss–dementia link. Rather, they evaluated how certain and credible the evidence appeared, and this assessment shaped how the message was understood and whether it was considered meaningful.

Trust in the hearing healthcare system

Participants also considered whether they could trust the people and organisations communicating the hearing loss–dementia link. Their accounts reflected both trust in individual clinicians and concerns that commercial interests could influence how the relationship was presented.

Some participants expressed trust in clinicians who they felt were acting in their best interest:

> *That's why it's all trust, right? You need an audiologist that you feel you can trust, that's gonna do the best for you, not just make the most money.*
>
> *—Pam, 69, CI*

However, others questioned whether messaging about the hearing loss–dementia link was motivated by patient benefit or commercial interests. After stating that her hearing care professional had "stressed" the link to her during an appointment, one participant questioned the motivation behind this messaging:

> *Well, I mean, there's a great deal of self interest in that… Clearly, the audiology people want you to buy hearing aids. So, the more that your hearing loss seems to be a major jeopardy, the more likely you are to go that route.*
>
> *—Fiona, 97, HA*

Another participant, who described a history of negative experiences navigating hearing healthcare, similarly felt that the link could be used to persuade people to purchase more expensive hearing aids:

> *… the hearing aid companies are no doubt trying to push it, to have people buy more. and I'm one of those who buy into crap like that, because… I want to be able to hear, I'll go into debt, I will do whatever I can… I dislike the hearing aid companies a lot.*
>
> *—Cheryl, 71, HA*

Concerns about commercial motives were particularly salient when participants encountered the link in promotional materials for hearing clinics. Bonnie (67, HA), for example, interpreted advertisements connecting hearing loss with dementia as an attempt to generate fear and promote hearing services:

> *Certainly you hear all the ads, "Oh, there's a link between dementia and hearing loss, you should go get your–" And you go in [the hearing clinic] and they have these screens with old people that say, "Are you afraid? Your hearing, memory loss, come get your –" … like, of all the things in your healthcare, why is hearing something that is completely within the commercial? It's terrible.*
>
> *—Bonnie, 67, HA*

These accounts suggest that trust operated alongside certainty in shaping participants' responses to the link. Confidence in the evidence affected whether the message was regarded as credible, while trust in the people and institutions communicating it affected whether that message was regarded as trustworthy and worth acting upon. Conversely, concerns about commercial motives could undermine the persuasive power of the message, even when participants recognised the possibility of a relationship between hearing loss and dementia.

Discussion

This qualitative interview study examined how older adults with hearing loss interpret and respond to messages about the hearing loss–dementia link. Findings demonstrate that participants actively constructed individualised understandings of the link, drawing on personal experiences, beliefs about actionability, and perceptions of credibility and trust. While some participants viewed the link as motivating changes to their hearing health behaviours, others questioned its relevance to their circumstances or interpreted its use in commercial contexts as contributing to distrust. These findings provide important context for clinicians responding to older adults' questions and concerns about how hearing interacts with cognitive health.

Active interpretation and personal sense-making

The current study demonstrates that older adults are active constructors of meaning when encountering health information (Theme 1: Making Sense of the Message). Consistent with broader qualitative research on health communication, participants did not take claims about the hearing loss–dementia link at face value (Larsen and Gilstad 2022). Rather, they interpreted these claims by integrating personal experience, intuition, informal knowledge, and selective engagement with scientific or professional sources, aligning with evidence that individuals interpret complex health information alongside their beliefs, experiences, and identities (Nikolaidou and Bellander 2020). Lived experience, especially family history of hearing loss and dementia, played a central role in evaluating the link's relevance to personal dementia risk. This mirrors research on dementia worry, which shows that personal exposure to dementia shapes perceived risk, often outweighing epidemiological or statistical evidence (Lee, Do, and Suhr 2021; Werner, AboJabel, and Maxfield 2021). These findings suggest that interpretations of the hearing loss–dementia link are embedded within emotionally salient personal narratives rather than solely in abstract understandings of population-level risk.

Previous work suggests that adults with hearing loss form cognitive representations about the cause, timeline, consequences, and modifiability of their hearing loss (Heffernan et al. 2016). Participants in the present study engaged in similar reasoning about the hearing loss–dementia link. Many independently theorised pathways linking hearing loss and cognitive decline that resembled dominant hypotheses in the scientific literature, including reduced auditory stimulation, cognitive load, and social isolation (Levett et al. 2025; Lin and Albert 2014). These interpretations were often framed as common sense rather than research-based knowledge, suggesting that scientific ideas about brain health may have diffused into public understanding (Budin-Ljøsne et al., 2022), even among individuals who do not actively engage with academic research. At the same time, this intuitive alignment may obscure important nuances in the evidence, as indicated by some participants' strong beliefs about a direct, causal relationship between hearing loss and cognitive decline.

Agency and understandings of ageing

Many participants viewed agency, effort, and continued social and intellectual engagement as pathways to maintaining their hearing and cognitive health. For some, knowledge of the link reaffirmed that they had "done the right thing," suggesting that agency-focused messaging can foster motivation and empowerment. However, participants whose hearing loss did not fit the normative pathway of age-related, treatable hearing loss often questioned whether the link applied to them. These individuals described frustration when recommended treatment approaches were unsuccessful and characterised the message as unactionable. These experiences suggest that common messages about hearing loss and dementia have the potential to provoke feelings of uncertainty, frustration, and alienation for those whose experiences do not fit the normative trajectory of age-related hearing loss.

This framing of hearing loss and cognitive health as a matter of personal responsibility mirrors broader scientific and media narratives surrounding hearing loss and dementia. Foundational studies reported population-level associations between hearing loss and dementia risk (Deal et al. 2017; Lin et al. 2013; Livingston et al. 2024), while subsequent media coverage emphasised implications for individual risk

reduction through hearing management (Blustein, Weinstein, and Chodosh 2023). Within these narratives, hearing loss is positioned as a modifiable risk factor, and hearing aid uptake as a potential means of reducing dementia risk. Such emphasis on individual responsibility aligns with dominant public health messaging around ageing, which positions older adults as capable of preserving health through adherence to health-promoting behaviours (Katz & Calasanti, 2015), including maintaining hearing health (Pichora-Fuller, Mick, and Reed 2015).

Situating these findings within ageing and public health literature highlights both the promise and limitations of agency-focused messaging. Such messaging has been criticised for framing health outcomes as matters of personal responsibility and, when outcomes are poor, as personal failings (Waddell et al. 2024). In light of this, many older adults with chronic illness or disability often construct their own ageing ideals, focusing less on avoiding disease and disability and more on adapting to it, accepting it, and enjoying life alongside it (Khamzina, Mejia, and Rogers 2024). Participants' accounts in the present study reflect this perspective: some described accepting and adjusting to their hearing loss rather than trying to change it, integrating knowledge of the hearing loss–dementia link into their process of acceptance rather than as a directive for action.

Overall, participants' accounts support public health initiatives that highlight the broader impacts of hearing loss and emphasise risk reduction and self-management (Pichora-Fuller, Mick, and Reed 2015), while illustrating the need for messaging that accommodates diverse experiences and avoids framing health outcomes as solely personal responsibility.

Implications for hearing healthcare

Our findings suggest that information about the hearing loss–dementia link may be incorporated into participants' accounts of their hearing health behaviours, with some participants describing the link as motivating help-seeking, reinforcing treatment adherence, or validating past decisions. These findings align with evidence that exposure to dementia information can help motivate positive health behaviour change (Khalil et al. 2025). Participants' accounts also highlighted ethical concerns regarding the use of dementia risk in hearing care. For some, messages linking hearing loss and dementia were interpreted as informative and helpful, whereas others viewed them through a lens of commercial interest and distrust. These findings reinforce previous work demonstrating the importance of trust in hearing healthcare engagement (McMahon et al., 2021). As Warren et al. (2026 May-Jun 01) suggest, trust is a particularly important factor in engagement with hearing healthcare for marginalised individuals, who may experience mistrust due to prior negative healthcare experiences and barriers to care. Our study highlights how trust, commercialisation, and access intersect in the context of hearing and dementia. Messaging about the hearing loss–dementia link that is not informative, thoughtful, and from a trusted source risks further alienating distrustful individuals from hearing care, potentially widening disparities.

Another finding relevant to clinical practice is that only a minority of participants reported having discussed the hearing loss–dementia link with an audiologist or other healthcare professional. Most indicated learning about the link through television or radio programming, news articles, or social media, consistent with recent Canadian survey data indicating that only about 10% of people aware of the link learned about it from an audiologist or other hearing care professional (Bobbitt et al. 2026). This is particularly relevant given that information encountered online and through the media may be inaccurate or misleading (Blustein, Weinstein, and Chodosh 2020; Herrmann et al. 2026). Although some clinicians and researchers have expressed concern that fear-based messaging about the link could discourage engagement with audiological services (Blustein, Weinstein, and Chodosh 2023; Dawes and Munro 2024), no participants in the present study reported that learning about the hearing loss–dementia link made them less likely to pursue audiological care, consistent with the low prevalence of avoidance reported in a Canada-wide survey (Bobbitt et al. 2026). However, our sample may be biased towards individuals more engaged with their hearing and cognitive health and may therefore not reflect the perspectives of those with greater avoidance. One participant reported that reading about the hearing loss–dementia link online caused him distress and led him to avoid seeking further information. Despite this, he expressed a strong desire to better understand his cognitive health and its possible relationship to hearing, frequently asking the interviewer for additional information. Together, these findings suggest that while hyperbolic or alarming messages may provoke anxiety or avoidance, individuals may nevertheless seek guidance from hearing healthcare professionals to help contextualise information encountered elsewhere.

Several other participants also asked the interviewer for clarification about the hearing loss–dementia link during the interview. These accounts suggest that many

individuals, even those aware of the link, still had unmet questions and concerns. Participants' desire for further information echoes prior research showing that individuals want detailed and accessible hearing health information (Parmar et al. 2022). When concerns and questions about hearing loss are not adequately met, individuals may be less likely to engage with audiological care (Ekberg, Grenness, and Hickson 2014). Thus, rather than avoiding the topic for fear of upsetting clients, clinicians might instead provide information and clarification about the link to support understanding, especially given that the hearing loss–dementia link is increasingly present in public discourse and many individuals may have already encountered it outside of audiological care settings.

Limitations

Several limitations should be considered when interpreting these findings. Our sample comprised older adults in Canada who self-identified as having hearing difficulties and were willing to participate in in-depth interviews. Participants may have been more reflective about hearing and health than the broader population; indeed, recent data indicate that knowledge of the hearing loss–dementia link is twice as high among more health-engaged individuals (Bobbitt et al. 2026). Such participation bias may limit transferability to individuals who are more socially isolated, have less healthcare access, or are less inclined to participate in research (Brayne and Moffitt 2022). Participants were also predominantly White, educated, and English-speaking. Future research might seek the perspectives of marginalised groups regarding their exposure to the hearing loss–dementia link and its role in hearing care.

As this research was conducted within a Canadian context, the findings should be interpreted in relation to a healthcare system that delivers hearing care largely through private providers and is not universally publicly funded, while health messaging is still regulated. This context offers a valuable lens for examining issues of trust, commercialisation, and decision-making in hearing healthcare. However, the transferability of these findings may be limited in healthcare systems where hearing care is primarily publicly funded or more tightly regulated, particularly with respect to participants' perceptions of trust and motivation to engage with hearing care services.

Another methodological consideration is the interchangeable use of the terms *dementia* and *cognitive decline*. Although related, these terms carry distinct meanings in clinical and research contexts. During interviews, the researcher primarily used the term *cognitive decline*, while participants referred to broader cognitive constructs such as memory, attention, or "mental sharpness." As these terms may be understood differently, they may have shaped how participants interpreted both the interview questions and information about the hearing loss–dementia link. This pattern of terminology use likely reflects broader variation in public understandings of cognitive health and dementia (Knopman and Petersen 2014). Consequently, the findings should be interpreted as reflecting participants' general understandings of cognitive health rather than precise distinctions between specific conditions.

Conclusions

This study explored how older adults interpret hearing loss–dementia messaging and how they make sense of these messages in relation to their own lives. Participants' understandings of the link were shaped by how credible, relevant, and actionable they perceived it to be. Interpretations ranged from strong endorsement of a causal relationship to uncertainty or scepticism, and perceived applicability varied depending on individuals' hearing loss trajectories and prior experiences. While some participants described increased motivation to initiate or maintain hearing care, others – particularly those who expressed distrust in commercial hearing healthcare contexts – viewed the messaging through a lens of scepticism that diminished its motivational impact. Overall, the influence of hearing loss–dementia messaging appears to depend not only on message content but also on delivery context, perceived credibility, and alignment with personal circumstances. By examining how trust and certainty interact with message interpretation, this study provides a nuanced understanding of how hearing loss–dementia communications are received and underscores the need for careful, credible, and sensitive audiological care.

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Author contributions

CRediT: **Sarah Bobbitt**: Conceptualization, Data curation, Formal analysis, Investigation, Visualization, Writing – original draft; **Signe Lund Mathiesen**: Conceptualization,

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